VOL. 19, NO. 4 1970

Inventory

A QUARTERLY JOURNAL ON ALCOHOL AND ALCOHOLISM
PUBLISHED BY THE N. C. DEPARTMENT OF MENTAL HEALTH

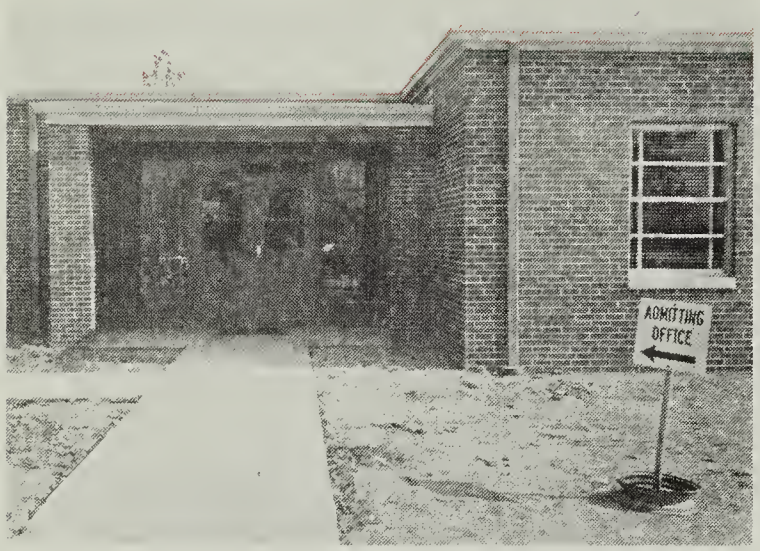
TREATMENT

REHABILITATION

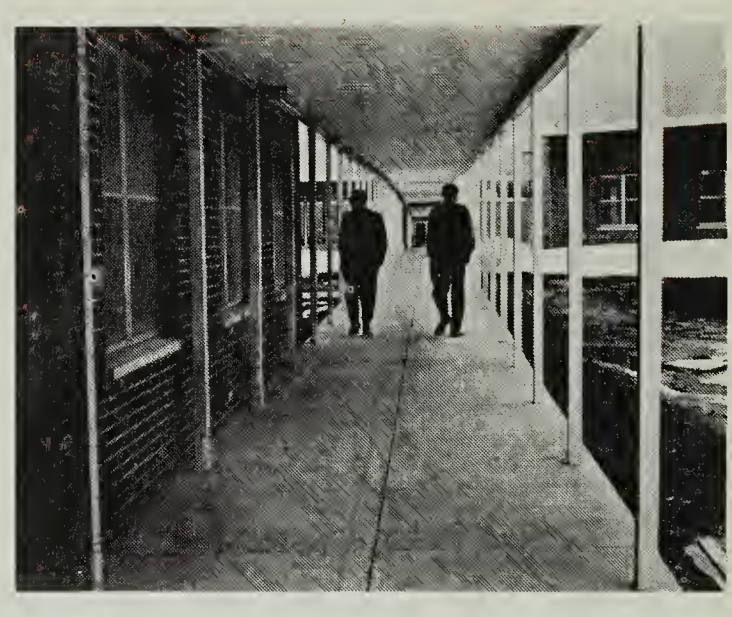
EDUCATION

PREVENTION

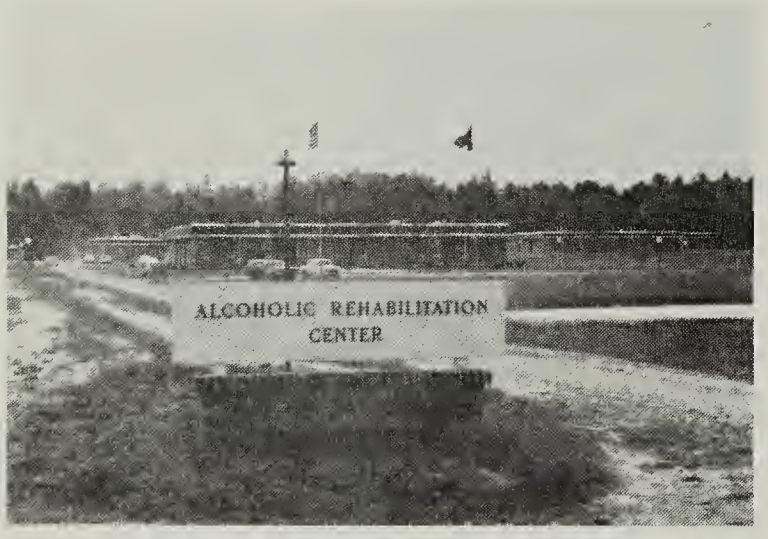
N. C. ALCOHOLIC REHABILITATION CENTERS



ARC AT Butner, North Central Region



ARC at Black Mountain, Western Region



ARC at Greenville, Eastern Region

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The ARC's, operated by the N. C. Department of Mental Health, are in-residence treatment facilities for persons with alcoholism. For the majority of patients the length of stay is 28 days. A fee of $7 per day is charged for the four weeks of treatment. This may be paid by cash or check at the time of admission or by an agreement signed by the patient promising to pay the full sum at some time after discharge. If a person is indigent he may obtain a letter from his local department of social service stating this fact and, upon presentation of this letter, request for payment will be deferred. No patients are refused treatment because of lack of money.

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INVENTORY

SPRING ISSUE

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Surveys, arrest records, increasing deaths due to overdosage of drugs, and the prevalence of illegal drugs in our society, all point to the fact that our nation is in the midst of a drug epidemic! Like it or not, drugs, very much like alcohol, are available to Americans of all ages, particularly to our youngsters.

We have been led to believe that the "dope peddler" is the "hoodlum looking" character, dressed in shabby clothes, fronting a menacing countenance, who slinks along the school yard fence "pushing" his wares to our high school teen-agers. Nothing is farther from the truth. The fact is drugs are distributed and received by peers who are usually introduced to them on an experimental basis.

As one police officer so well put it, "Pill heads beget pill heads; weed heads beget weed heads; acid heads beget acid heads; and junkies beget junkies."

There is a great need today for sound drug education based on scientific principles.

A Logical Approach to the Growing Drug Problem

BY ASHTON BRISOLARA, M.ED.
EXECUTIVE DIRECTOR
COMMITTEE ON ALCOHOLISM
AND DRUG ABUSE
FOR GREATER NEW ORLEANS

Is it any wonder we are experiencing this growing drug abuse and addiction problem? We live in a drug-oriented society, surrounded by countless chemical comforts. There are pills to take when we awake, some to "kick off" the day at breakfast, pills to pep us up, to keep us awake, to sustain health, to gain weight, to lose weight, to give us energy, to sedate, to cope with our problems and tensions, to put us to sleep and even to control nature's most delicate miracle—conception.

As a nation, we have become so brainwashed with chemical crutches for our hangups that we have become, rightly or wrongly, a country of "pill heads."

Under the direction of a physician, drugs can be most helpful to man. In just the past few decades, we have witnessed the miracle drugs eradicate some of man's most dangerous illnesses and killers. Abused, however, drugs can cause havoc, pain, confusion, addiction, and death.

There is no doubt that some Americans abuse the use of legal drugs, perpetuating their habit by seeking out a host of physicians who, unknowingly, provide the abuser with a continued source of their chemical crutch. But the most frightening fact of the problem is the increased incidence of illegal drugs. Heroin, LSD, amphetamines, etc. are circulated among young adults and teen-agers with little knowledge of their potential dangers.

There was a time when drug addiction and abuse was confined to the ghetto. This is no longer true. There is as much experimentation, if not more, with drugs and abuse of drugs among the affluent segments of our society as among the lower economic groups. The availability of drugs, and the economic affluence of our youth facilitate the problem.

Who uses drugs? Anyone can. No

one is immune. Youngsters usually take their first "weed," "shot," "pill," or "trip" to be one of the gang, to be accepted, to be "in." For most, it is probably a one-time or several-time affair.

However, because of the psychological differences which exist in human beings, some users of drugs find it appealing, comforting, a momentary solution to problems, and "out" for their "hangups." They continue, increase their dosage, experiment with other stronger substances, and oftentimes become habituated or addicted.

Whatever be the situation or problem: wish to be accepted, relief of anxieties or tensions, an "out," an eagerness for exhileration, desire for the fanciful and "beautiful," the "needle," "stick," "acid," "pill," etc. is not the answer.

While most states prescribe the teaching of the "evils of alcohol, tobacco and drugs," the quality of presentation and education are oftentimes questionable. Teachers are frequently uncomfortable in dealing with these delicate subjects, unless they have been specially trained; and, unfortunately, even when comfortable and knowledgable, they many times approach the subjects on a moralistic note.

Much is said today about the "generation gap." The term is very much maligned. The generation gap has always existed. We called it by different terms, but it was there. We adults "turned off" our so-called "establishment representatives" when we felt they demanded our decisions to be made according to their wishes.

Parents and teachers always hope and pray that their children and students will not drink, smoke or use drugs. However, negative approaches will probably only encourage experimentation, either by the mystery negation creates or by outright defiance of authority.

There is a great need today for sound drug education based on scientific principles, presented in a fashion that will "tune in" our youngsters, give them the information they need on which they can make a wise decision. And they *will* make the wise decision if we but give them adequate information, and example.

Unfortunately, in a desperate move to head off the epidemic, many individuals and communities have pushed the panic button and have initiated overnight programs and projects which, while well-intentioned, are oftentimes poorly directed.

There is room for everyone in this important venture of "drug alert." There is room for clergymen—who will not preach; for teachers—who will not prohibit; for law enforcement officers—who will not threaten; for narcotic addicts who have recovered —who will not deviate from their role and avoid glamorization of crime and the thrills of certain drugs; and for volunteers—who are properly educated and willing to work.

A little knowledge is sometimes very dangerous. And today too many half-hearted and poorly directed approaches are being devised to attack the drug problem, with many poorly directed individuals and groups climbing on the bandwagon to do their "thing."

Perhaps the most logical center of activity in the new addiction problem we are experiencing is the alcoholism council, committee or center which has had long years of experience in an allied field of addiction—alcoholism. Through this medium, we might be able to avoid the pitfalls sure to appear.

It might well be a worthwhile consideration, for the good of society, for alcoholism agencies to consider expanding their educational services into this much needed field. It is where it rightly belongs!

Developing and providing alcoholism programs and services is everybody's business.

Dr. James W. Osberg, eastern regional commissioner of mental health for the N. C. Department of Mental Health, presented this paper at the 1970 Eastern Regional Summer School of Alcohol Studies conducted at East Carolina University, Greenville, N. C.

Comprehensive Alcoholism Services in North Carolina

BY JAMES W. OSBERG, M.D.

Alcoholism, the third leading health problem in the nation, has long been neglected. But in the past few years, interested in doing something about the problem has increased. Legislation has been passed, and action has resulted. We are now in the midst, nationally and here in North Carolina, of developing imaginative, dynamic programs of prevention, treatment and rehabilitation.

The problem is no longer the concern of one agency, one group or one profession. It is a problem facing all major health and welfare agencies (federal, state and local) and practically all departments within these agencies, and all the helping professions. If we are ever to meet the demands and needs now upon us, all agencies, groups, professions and disciplines must assume their respective roles and responsibilities in the development and implementation of a comprehensive network of alcoholism programs and services.

In short, developing and providing alcoholism programs and services is everybody's business. Said another way, the problem of alcoholism is so great that no one agency, group or profession can, by itself, begin to meet the needs; no one agency, group or profession has the qualifications, skills and experience, and neither does any agency, group or profession have the finances, staff, skills or the facilities to do the job that must be done.

Alcoholism is a major medical-social economic problem that requires an interagency, inter-professional, public-action program, aimed at every level of society, with the emphasis on developing community programs, services and facilities, working together as a team, and *sharing resources, staff, finances and determination.*

Six years ago it was considered novel to expect the U. S. Congress to give consideration to national alcoholism legislation. Today, it is a reality. The year 1968 will go down in the annals as the great year for breakthrough and accomplishments in the field of alcoholism because of the passage of the Alcoholism Rehabilitation Act of 1968 by the 90th Con-

gress. This act was signed into law November 15, 1968 as an amendment to the 1963 Community Mental Health Centers Act.

Another legislative victory was occasioned by the passage of the 1967 Poverty Bill which included an amendment by Senator Jacob Javits of New York making alcoholism a priority consideration for activity by the Community Action Programs of the Office of Economic Opportunity.

More than 100 members of the 90th Congress affixed their names to alcoholism legislation. The results of united efforts with the 89th Congress also paid handsome dividents. Although no specific alcoholism legislation was enacted by the 89th Congress, the interest generated there, in the Department of Justice and in the White House, resulted in the establishment of the National Center on Alcoholism and the National Advisory Committee on Alcoholism.

Both of these significant steps were requested by the President in his Health Message to Congress of 1966. This was the year that the *Easter* and *Driver* decisions in the Federal Circuit Courts of Appeals made it unlawful to hold homeless chronic alcoholics criminally responsible for simple displays of public intoxication. Two presidential crime commissions, independently, had recommended that alcoholism be treated as a public health problem and not a criminal problem. Armed with these court decisions and the crime commission's recommendations, the President asked for establishment of the National Center on Alcoholism as part of the National Institute of Mental Health; and, at the same time, he asked for the establishment of a National Advisory Committee on Alcoholism to aid the Secretary of Health, Education, and Welfare to determine appropriate activity by the department in this now recognized major problem area.

In the 91st Congress, 1969, the Sub-committee on Alcoholism and Drug Abuse was established with the Honorable Harold E. Hughes, Governor of the State of Iowa, as committee chairman. This committee is the only committee of its kind in the history of the U. S. Congress, a sub-committee with designated responsibility for alcoholism and drug abuse.

We are now on the threshold of a new era in the field of alcoholism; an era which will see an end to the medieval, outmoded, inhumane system of punishing alcoholics for simple displays of public intoxication; an era which will see the federal government, at long last, join as a full partner with state and local governments in a concerted effort to bring one of the

nation's leading medical-social problems under control; an era which will see the uniting of many allied disciplines in seeking solutions to this complex problem.

Our jobs from now on will be far more difficult than they have ever been before. We must now prepare to meet the exciting challenges which we have before us. We now have our mandate from the national level. Likewise, we have our mandate in the State of North Carolina. The Department of Mental Health and its Division of Alcoholism now have the responsibility for the development of a comprehensive network of alcoholism programs and services in the state, including the 32 counties of the eastern region that you, the participants of this school of alcohol studies, represent.

Significant Fact

The fact that the Alcoholism Rehabilitation Act of 1968 became an amendment to the Community Mental Health Center's Act of 1963 is significant. In essence, this made the development of alcoholism programs and services a responsibility of state and local mental health authorities, and identified alcoholism programs and services as an integral and essential part of community mental health services. Likewise, it spelled out the concepts of what is needed in alcoholism and should be included in a complete range of services as an identified and integral part of community mental health programs and services.

Before attempting to interpret the range of services needed in alcoholism, we need to understand the concept of the community mental health center, its basic objective, the services it provides and how it operates.

First, the community mental health center is broader in scope and offers a much greater range of services than the traditional mental health clinic. Its basic objective is to provide services with the other agencies in the community it serves, to coordinate services with other agencies, with the state and with the federal comprehensive health program for the nation.

Even though the objective is to provide a complete range of services, the community mental health center, depending upon resources and the community it serves, may not be able to provide all the services needed or desired, particularly in its earliest stages of development. There are, however, five essential services that are required, at least to some degree, in order to qualify for matching federal funds. These are:

1) *Inpatient care*—providing treatment for a limited time for patients needing around-the-clock care.

2) *Outpatient service*—offering a variety of individual and group treatment programs, including pre-hospital and post-hospital services.

3) *Partial hospitalization*—providing at least day or night care and treatment for patients able to return home to work or to be cared for elsewhere at other times.

4) *Emergency care*—supplying a 24-hour emergency service for adults, children and families when needed, without a waiting period.

5) *Consultation and education*—establishing consultative and educational services to community agencies and professional personnel such as physicians, clergymen, schools, health departments, courts, police, welfare departments, voluntary health and welfare agencies, and education of the general public.

A fully comprehensive center, with a complete range of services, in addition to the five essential services would also include:

1) *Diagnostic services*—providing evaluations for specialized needs such as those of courts, schools, etc., and

may include recommendations for appropriate care.

2) *Rehabilitative services*—including both social and vocational rehabilitation. To coordinate for those who need them such services as prevocational testing, guidance counseling and sometimes, job placement.

3) *Precare and aftercare*—providing screening of patients prior to hospital admission and home visitation before and after hospitalization. Follow-up services for patients should include the availability of outpatient clinics, foster homes and/or halfway houses, and again a mechanism for coordinating the full utilization of all other agency services pertinent to the patient's recovery in the community.

4) *Training*—including inservice training and staff development programs for all types of mental health personnel, the center staff, related professionals and nonprofessionals, personnel from other agencies and interested laymen, volunteers, etc.

5) *Research and evaluation*—focused on methods of evaluating the effectiveness of the center program. It may also carry out research into mental health problems or cooperate with other agencies in research projects.

To implement comprehensive mental health programs in North Carolina, the Department of Mental Health is decentralized into four regions. Each of these regions has a deputy commissioner who is immediately responsible for all mental health services (including alcoholism) in his region. Program leadership is the responsibility of the deputy commissioner on alcoholism.

To assist in programming and quality control each of the four regions has one regional alcoholism program director and one regional program coordinator.

In three of these regions, we have an Alcoholic Rehabilitation Center (an impatient intensive treatment facility), plus a mental hospital in each region that has specified responsibilities in the area of alcoholism. The counties of the fourth region have access to the ARC treatment.

A further breakdown within the four mental health regions is what we commonly refer to as the geographic mental health area consisting of a large county or a multi-county area having a population not less than 75 or more than 200 thousand population. There is a total of 44 such areas in the four regions.

The development of alcoholism programs and services in North Carolina, under the auspices of the Department of Mental Health, is predicated on the following principles:

1) Alcoholism is an illness of multiple causation involving the physical, emotional, social and spiritual well-being of its victims and adversely affects the individual, his family, his friends and the community.

2) Alcoholism is a public health problem of great magnitude and must be evaluated, diagnosed and treated as such.

3) Any effective community alcoholism program aimed at prevention and control of alcohol dependency must be comprehensive in scope and balance to include education, early detection, counseling, referral, treatment, rehabilitation, training, research and evaluation.

4) The problem of alcoholism is of such magnitude and the variety of services and programs needed is so great that no one agency, group or profession can do the job alone.

5) Practically all our major health, education, welfare, social agencies, and professional groups are constantly confronted with alcoholism problems, and in most cases, each has a potential role and can provide needed services not otherwise available or financially feasible.

6) To develop an effective alcoholism program influencing cultural practices and knowledge, economics and individual characteristics of the community must be considered, the people must be involved in the process of development and the program must be understood by, and accessible to, the people it is designed to serve.

These principles form the basic philosophy of our program and our methods of approach are guided by these principles. In other words, the only feasible plan for seeking solutions to the problem of alcoholism is through an *epidemiological, inter-agency, inter-professional, public-mental health approach aimed at developing programs and services at the community level, with the state providing specialized inpatient services.*

This philosophy and method of approach more specifically defines the Department of Mental Health and its Division of Alcoholism's chief functions as: *Providing the leadership for program development; creating interest and involving community leaders, agencies and professionals; education; training; planning; promotion; coordination; and consultation.*

The Division of Alcoholism's major area of concern is and must continue to be program development, with emphasis on establishing local alcoholism programs (including alcoholism information centers) that devote themselves to education, motivation and involvement for community action, resulting in development of resources and creation of services needed at the local level, provided by a multiplicity of agencies.

In the promotion and development of comprehensive alcoholism programs and services that include the range of services previously described, and in terms of the principles, philosophy and methods which I have just presented, the North Carolina Department of Mental Health sees alcoholism programs and services as an integral and identified part of community mental health programs, and sees the alcoholic and members of his family as patients eligible for any or all applicable services offered by any community mental health center.

To insure this program concept, in our state plan for mental health and in our approval of local mental health plans, alcoholism plans, programs and services are considered an essential part of any approved mental health program. Community plans for mental health services must include (within the limits of finances available) identified program, identified staff and identified expenditures for alcoholism.

Such a program plan should include:

1) Narrative description of the area to be served.

2) Narrative, including available data, as to the need for alcoholism services.

3) Present staff and description of present services being rendered.

4) A program plan for the expansion of the program that includes: a) purpose; b) program objectives; c) area to be served, including any breakdown by county; d) types of alcoholism services to be provided to the alcoholic, his family and the community; e) staffing pattern for the delivery of alcoholism services, including full or part-time alcoholism staff; f) supporting mental health staff members by professional categories and support services they are to provide, including a percent of time estimate; and g) a budget statement and narrative justification.

In the development of a network of alcoholism services in the eastern region, we have four basic program components:

1) Twelve community alcoholism

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VOL. 19, NO. 4 INVENTORY 1970
ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

A Pilot Study

Do Children Seen in Mental Health Clinics Come from "Problem Drinking" Households?

BY LACOE B. ALLTOP, M.S.P.H., DOROTHY LEMLEY, M.A. AND TREVOR WILLIAMS, M.D.

Norbert Kelly, Ph.D., director of the Division of Education of the North Carolina Department of Mental Health, has professed for some time that many of the children seen in mental health clinics come from households where a problem drinker is involved. Two mental health centers, the Coastal Plains Mental Health Center and the Rutherford County Mental Health Center, agreed to do a pilot study in order to get some idea about the magnitude and prevalence of this problem. In the beginning, information was collected only on patients under 21 years of age. Later, the study was expanded to include adults.

Three questions were asked each patient admitted: 1) Is there a drinking problem involved? If "yes," 2) What is the relation of the problem drinker to the patient? and 3) Does the problem drinker live in the household? This information was recorded on the regular clinic statistical reporting form (DMH-611).

In the study, drinking was defined to be a problem when a person became incapacitated in his every day functions due to the consumption of alcoholic beverage. The patients were queried and the information noted at the time of admission. Information was collected from March 1, 1968 to March 31, 1970.

During this 25-month period 1417 patients were asked whether or not a drinking problem was involved, and 599 (42.3 percent) answered "yes." This is shown in Table I.

Looking at the less than 21 "yes" age group in Table I approximately one out of three reported a drinking problem involved. At the Coastal Plain clinic four out of ten in this age group fell in the "yes" category, whereas at Rutherfordton it was about half of that ratio—two out of ten. There may be many factors as to why this difference occurred, such as geographic locations, cultural difference and ethnic factors.

In the second age group, 21 years and older, approximately 46 percent answered affirmative. In the "21 and over" age group other differences

The authors and their affiliations are: Alltop, biostatistician, Division of Research, N. C. Department of Mental Health; Lemley, assistant director, Coastal Plains Mental Health Center; and Williams, director, Rutherford County Mental Health Clinic. They acknowledge, with appreciation, the valuable assistance of the Division of Statisics and, particularly, Priscilla Chao who compiled the statistics.

Table No. I

Drinking Problem Involved
March 1, 1968—March 31, 1970

	Total		Less 21 yrs age		21 and over	
	No.	%	No.	%	No.	%
Total	1417	100.0	441	100.0	976	100.0
Yes	599	42.3	152	34.5	447	45.8
No	818	57.7	289	65.5	529	54.2
Coastal Plain MHC	770	100.0	268	100.0	502	100.0
Yes	366	47.5	115	42.9	251	50.0
No	404	52.5	153	57.1	251	50.0
Rutherford MHC	647	100.0	173	100.0	474	100.0
Yes	233	36.0	37	21.4	196	41.4
No	414	64.0	136	78.6	278	58.6

were not as great, 50 percent versus 41.4 percent.

Out of the 1417 patients queried, 599 indicated there was a drinking problem involved.

The next question pertaining to this group was whether or not the problem drinker lives in the same household. Table II reveals the distribution regarding this question:

In Table II the two clinics show a different distribution regarding the residence of the problem drinker. At the Coastal Plain Mental Health Center one out of three resided in the same household, whereas at the Rutherfordton County Mental Health Center approximately nine out of ten did. The total shows that a little over one-half (54.3 percent) of problem drinkers resided in the same household. Again, the factors causing such a large difference between the two centers may be the same as previously stated.

The next pertinent question deals with the relationship of the problem drinker to the patient. Table No. III gives the frequency distribution and Table No. IV gives the percentage

Table No. II

Drinker Live In Same Household
March 1, 1968—March 31, 1970

	Number			Percent		
	Total	Yes	No	Total	Yes	No
Total	599	325	274	100.0	54.3	45.7
Less than 21	152	72	80	100.0	47.4	52.6
21 and over	447	253	194	100.0	56.6	43.4
Coastal Plain MHC	366	122	244	100.0	33.3	66.7
Less than 21	115	46	69	100.0	40.0	60.0
21 and over	251	76	175	100.0	30.3	69.7
Rutherford MHC	233	203	30	100.0	87.1	12.9
Less than 21	37	26	11	100.0	70.3	29.7
21 and over	196	177	19	100.0	90.3	9.7

Table No. III

Drinker's Relationship to Patient
March 1, 1968—March 31, 1970

	Relationship							
	Total	Father	Mother	Sister	Brother	2 or More	Others	Self
Total	599	149	23	5	17	74	161	170
Less than 21	152	76	11	—	2	21	32	10
21 and over	447	73	12	5	15	53	129	160
Coastal Plain MHC	366	125	20	4	15	69	111	22
Less than 21	115	60	8	—	1	16	25	5
21 and over	251	65	12	4	14	53	86	17
Rutherford MHC	233	24	3	1	2	5	50	148
Less than 21	37	16	3	—	1	5	7	5
21 and over	196	8	—	1	1	—	43	143

distribution.

In both centers the father was reported as the problem drinker in the "less than 21" age group in approximately one-half of the reported cases. This percentage is believed to be somewhat low as the father, no doubt, was included in the category where there were two or more drinkers in the family. Out of the 1417 cases reported, 170 stated that they were the problem drinker. This accounted for about 12 percent of those admitted during this period of time.

In summary, this study shows that a drinking problem was involved in approximately one-third of the patients who were less than 21 years of age admitted to these two mental health centers. In at least 50 percent of cases the father was the problem drinker. In slightly less than 50 percent of the time, the problem drinker lived in the same household. Also, it was noted that about 7 percent of the problem drinkers in this age group listed "self" as the drinker.

Looking at the total population, where information was collected, we

(CONTINUED ON PAGE 20)

Table No. IV

Drinker's Relationship to Patient
March 1, 1968—March 31, 1970

	Percentage							
	Total	Father	Mother	Sister	Brother	2 or More	Others	Self
Total	100.0	24.9	3.8	0.9	2.8	12.3	26.9	28.4
Less than 21	100.0	50.0	7.2	—	1.3	13.8	21.0	6.7
21 and over	100.0	16.3	2.7	1.1	3.3	11.9	28.9	35.8
Coastal Plain MHC	100.0	34.2	5.5	1.1	4.1	18.8	30.3	6.0
Less than 21	100.0	52.2	7.0	—	0.9	13.9	21.7	4.3
21 and over	100.0	25.9	4.8	1.6	5.6	21.1	34.3	6.7
Rutherford MHC	100.0	10.3	1.3	0.4	0.9	2.1	21.5	63.5
Less than 21	100.0	43.2	8.1	—	2.7	13.6	18.9	13.5
21 and over	100.0	4.1	—	0.5	0.5	—	21.9	73.0

Searching for New Ideas

We would deeply appreciate your placing the N. C. State Commission for the Blind on your mailing list for *Inventory*. As a state agency dealing with adolescents and young adults, we are constantly searching for new programs and new ideas relating to such problems as alcoholism and drug addiction.

Louis J. Finkle
Raleigh, N. C.

Group Visits Hospital

A copy of your publication, *Inventory,* has been handed to me by a friend. I am in charge of a church group which goes regularly to Cherry Hospital to visit the alcoholic patients and have hymn-sings with them. I would greatly appreciate your including me on your mailing list.

Virginia Crow
Goldsboro, N. C.

Used In Medical Library

Inventory is a most welcome addition to our Medical Library collections which are being organized with a view to serving not only the staff and students of the University College School of Medicine, but also all who are in any way concerned with research in medicine and its related services in Rhodesia.

Miss D. M. Colliers
Salisbury, Rhodesia

Teen-age Teacher

Someone just gave me a copy of the Vol. 19, No. 2 *Inventory* which contains some valuable information that I'd like to use in teaching the teen-age boys and girls in our youth meetings of the Youth Temperance Council of the Woman's Christian Temperance Union. Please send me *Inventory.*

Mrs. Viola Brown
Greenville, N. C.

Lay Therapist Writes

Could you please put me on the mailing list to receive *Inventory*? I am an alcoholic and am working with the local VA Hospital here in Phoenix as a lay therapist. Thank you.

Annonymous
Phoenix, Arizona

Family Counselor

I work in the alcoholic rehabilitation program here at Austin State Hospital, with families of the patients, as family counselor and know that *Inventory* would be of immense value to me. Could I be put on the mailing list.

Mrs. Nedra P. Marsh
Austin, Texas

Outreach Worker

In my work as an outreach worker for the local community action program I certainly find alcoholism a singularly striking symptom of social disintegration. Could I be put on the *Inventory* mailing list?

Cynthia C. Moore
Winston-Salem, N. C.

Treatment Foundation

Would you please put me on the list to receive your quarterly journal? I am an addictions counselor at Emmanuel Convalescent Foundation. We treat Roman Catholic priests exclusively.

J. K. Davis
Aurora, Ontario

Estimates in a recent bulletin of the Department of Health, Education and Welfare claim that there are at least 6½ million, perhaps 8 million, alcoholics in the United States. Since it is believed that each alcoholic directly affects at least four other people—of the family or other significant persons in his life—there may be some 26 to 32 million persons directly affected by alcoholism. According to the World Health Organization, the United States has moved ahead of France as the nation with the highest incidence of alcoholism.

It is also important to note that only approximately 5 percent of all alcoholics are the so-called skid-row type. In fact, some authorities who have studied skid rows in large cities are beginning to believe that many of the so-called "skid-row bums" are not alcoholics at all. Despite this, many so-called "well informed and educated people" believe the myth that a person cannot be an alcoholic without being a "skid-row bum." Some professional people who work in slum areas in our own state have told me that they have the same impression, that is, that all alcoholics are the "skid-row type." We need to educate all persons in the community to the truth that the overwhelming majority of alcoholics in the United States are living with their families, holding some kind of a job, and making some attempt to maintain their proper place in the community. Some, admittedly, are doing miserable jobs, and we must help them.

Statistics also show that exesssive drinking is a factor in about 50 percent of all arrests, at least 40 percent of traffic deaths, and over 50 percent of traffic accidents. The Federal Bureau of Investigation reported over two million arrests for drunkeness in a recent year.

Insurance company figures put the life expectancy of an alcoholic at about 10-12 years *less* than the aver-

Almost everyone has something to contribute to alleviating alcoholism, a huge complex, but treatable, problem.

An Overview of Alcoholism

BY R. J. BLACKLEY, M.D.

Dr. R. J. Blackley, the N. C. Department of Mental Health's commissioner on alcoholism, presented this paper at the 1970 Eastern Regional Summer School of Alcohol Studies conducted at East Carolina University, Greenville, N. C.

age person. Local communities in some states claim they spend between 50 and 100 thousand dollars on an alcoholic and his family during his life. Industry loses over 2 billon dollars a year based on an estimated average loss of $1,250 for each of its approximately 2 million alcoholic employees. These facts indicate that one way we can help alcoholics is by working with industry to develop appropriate programs of prevention and treatment. It would cost less and be more humane to have proper programming in this area.

As many of you who have been in this field for some time know, there are many definitions of alcoholism. I would like to present for your consideration the one which has been adopted by the American Medical Association and recommended by the Prime Study Group of the Institute of Rehabilitative Services. It is a rather broad definition, and I think that, because of the complexity of the problem and lack of precise knowledge about the causes and types of treatment, we have no alternative but to accept the broad viewpoint at this time. The definition is:

Alcoholism is characterized by preoccupation with alcohol and loss of control over its consumption, such as to lead usually to intoxication if the drinking is begun; by chronicity; by progression; and by tendency towards relapse. It is typically associated with physical disability and impaired emotional, occupational and/or social adjustments as a direct consequence of persistence and excessive use.

As you can see from this definition, alcoholism is a condition that seriously interferes with the patient's total health and his relationship with his family and environment. The key words of the definition are chronicity, progression and tendency to relapse.

It would be great if we could get a vaccine and do away with alcoholism as we did poliomyelitis. And, of course, we must continue to look for precise causes and methods of prevention, treatment and rehabilitation. For example, some recent research revealed an opium-like derivative in the blood of some alcoholics and has caused some scientists to speculate that perhaps this is what brings about addiction in certain alcoholics. However, more research needs to be done in this area and is being continued.

In contrast to the dearth of precise causes and treatments, there seems to be a steady progression of signs and symptoms of alcoholism that often overlap one another. Many observers talk about three stages: the pre-alcoholic, early stage alcoholic and later stages.

In much of the literature, the authors describe the pre-alcoholic symptoms as gross drinking behavior, gulping and sneaking drinks and blackouts. The early stage alcoholic symptoms have included loss of control over drinking, the development of an alibi system, the need for eye-openers, drinking by oneself, changing patterns of drinking, anti-social behavior, loss of friends, loss of job and family and the need for hospitalization or inpatient services. The later stages have included going on benders, unreasonable fears and anxieties, unreasonable resentments and behavior, withdrawal symptoms and collapse of the alibi system.

I would like to emphasize that all alcoholics are not alike, that these progressive-type symptoms often overlap and that what might be "bottom" for one person might well be different from that of another. In my opinion it is very difficult to place the symptoms in particular stages. For instance, I think a person who is beginning to have blackouts is far along the way not in the early stage.

In discussing the causes or etiology

of alcoholism in greater detail, we might start by recognizing that it is a complicated illness that is medical, psychological, physiological, sociological and spiritual both in origin and development. The many attempts to find a single or simple etiology so far have been unsuccessful, and I believe the reason for this is that there are different types of alcoholism and we can not or should not place all alcoholics in one category. For instance, there are persons who have difficulties with the abuse of alcohol who are mentally retarded. There are some who have had severe emotional illness (schizophrenia, manic-depressive psychosis, psychotic depression). There are some in the later stages of alcoholism and the elderly who have chronic brain syndromes, some who are neurotic abusers and some with character disorders.

Learn Truths

There are certain basic facts and truths about alcohol and alcoholism that everyone needs to know, and it is our duty to learn and tell the truths and expel the false ideas. For example, we know that alcohol is a depressant to the central nervous system, not a stimulant as many people believe. Another false idea that people have been taught is that alcohol will coagulate the brain. Actually it is impossible for anyone to drink enough or fast enough to coagulate the brain because the person would have died from complications prior to that.

Although alcohol is essential in the development of the illness, I don't believe that it is any more logical to state that alcohol by itself causes alcoholism than to state that marriages cause divorces.

Another mistake many of us make is using abstinence as our sole criteria for measuring progress in treatment. The person who stops drinking completely and ends up with a more severe illness hasn't made progress, he's worse off. If we can make the relapses fewer and farther apart, we have accomplished something and may learn from it how to assist these persons to recover. The person whose drinking problem is lessened, who gets along better with his family and community has made progress. When the chronic, down and out alcoholic begins to get help with his personal problems, begins to become a better parent, goes on a spree less often, has longer periods between sprees, he is making progress.

One theory is that alcoholism is an allergic reaction; however, in the medical sense there seems to be no similarity between alcoholism and the known allergies. There may well be an unusual response of the body to alcohol or the many impurities found in some alcoholic beverages. I would not rule out the possibility that certain persons who have problems with alcoholism have some physiological response such as this. But a great deal of study and research must be done in this area before it can be proved.

However, the apparent differences among individuals in their physiological response to alcohol, according to the latest information I have gathered, indicates that it is not an inherited problem, although there may be a tendency toward it. It seems to me though that there are more psychological, sociological and environmental factors than physiological ones.

What about the so-called "alcoholic personality" in regards to the causation of alcoholism? Although there are certain personality characteristics that are thought of as "alcoholic" characteristics, they are not common among all alcoholics. Some of these frequently mentioned characteristics are excessive dependency needs, feel-

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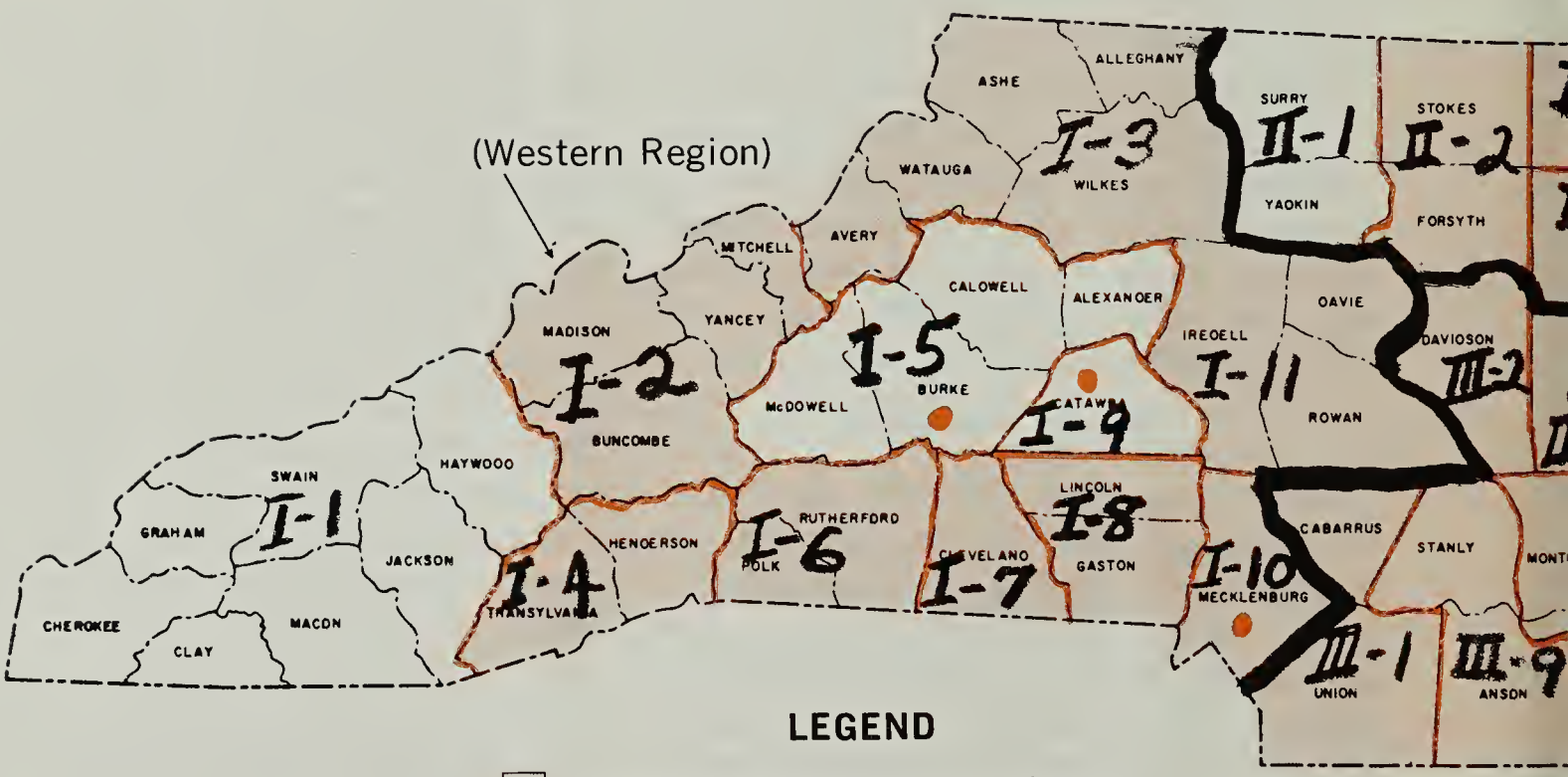
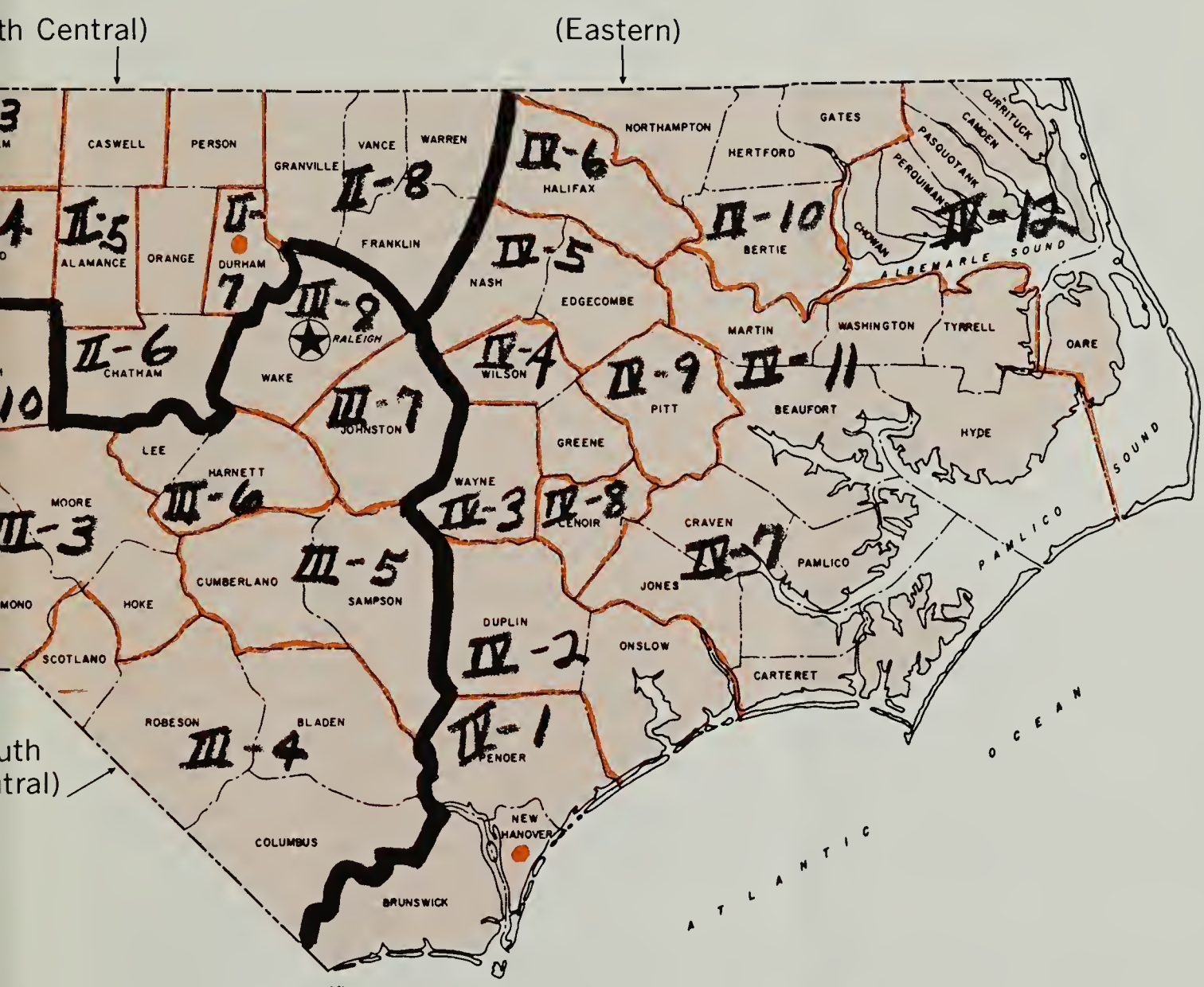
Counties in North Carolina Se
and Program



LEGEND

- Counties served by identifiable alcoholism program components in mental health centers and/or community alcoholism programs that receive funds from the N. C. Department of Mental Health
- — Divides counties into regions
- — Divides regions into areas.
- ● Community alcoholism programs supported solely by county or city Boards of Alcohol Beverage Control.

ed by Alcoholism Programs
Components



ings of guilt and remorse, loss of interest, denial of the problem, passive and aggressive behavior, indefinable fears, obsessiveness, compulsiveness, loss of self-esteem, etc. I think it would be remarkable if we did not find certain common characteristics because of the complexity of the problem. But I think it would be just as remarkable if we found a uniform characteristic. The fact is that psychological testing has not revealed any definite "alcoholic personality" that can serve either as a diagnostic measure or basis of treatment.

Again, I would like to impress upon you the fact that alcoholics are individuals and that we need to evaluate the individual abusers of alcohol rather than lump them all into one category. A recent survey of chronic alcoholic offenders who were picked up for public drunkenness and sent to the Department of Corrections illustrates this point. In this study it was found that approximately 1/6 were mentally retarded, 1/6 were schizophrenic, 1/6 were chronic brain syndromes, and the rest were mixed neurotic and character disorder types. The director of mental health programs in the Department of Corrections is beginning to screen alcoholic abusers and is working with the regional alcoholism program directors of the Department of Mental Health to plan better treatment programs for selected patients in that department.

Certainly up until this time I think we have erred in putting all alcoholics into the same type treatment program. Certainly we cannot treat a mentally retarded person the same as a schizophrenic or manic-depressive or chronic brain syndrome, or other severe mental illnesses the same as a neurotic person or persons with less serious personality difficulties. I believe that every effort should be made to screen persons from the psychological, medical and sociological standpoints in an effort to make a more accurate diagnosis and to determine what kind of program would be best suited for this individual. I believe we can learn more about how to help alcohol abusers learn to deal and cope with problems of everyday living by establishing better coordination and programming between local communities and the inpatient facilities.

From the physiological standpoint there are many theories that have been advanced as contributing factors with which we are not all in agreement and with which we sometimes strongly disagree. These are the theories that are based on the finding of endocrine imbalances, metabolic deficiencies, glandular dysfunctions and dietary and vitamin deficiencies. At the present time studies are being made to prove or disprove these factors as being contributory.

On the other hand if there are common symptoms in persons who have difficulties in the abuse of alcohol, I would say they are difficulties with interpersonal relationships, depression and tendency to relapse. Also, there are predominant factors in the psychological area and strong emotional components that are very complex and difficult to categorize.

For instance, there seems to be a self-destructive aspect to alcoholism either of the violent or slow, progressive variety. As you know alcohol is often associated with suicide and other acts of violence.

Also, our society is quite ambivalent in its attitudes toward drinking, and misbehavior and drinking. These attitudes vary from very liberal permissiveness to absolute abstinence. Both extremes have their drawbacks. Although some churches are begin-

ning to look at drinking differently than ever before, as a general rule among most believers in total abstinence no exceptions can be tolerated nor condoned. While there are different kinds of permissiveness, I would like to briefly mention a *positive* permissiveness that occurs in certain cultural groups which have very permissive attitudes but few problems with alcohol. For example, you rarely see a Jewish person who has a very deep problem with alcoholism unless he has a more severe emotional problem. Drinking is permitted in the Jewish culture, but excessive use and overindulgence is not tolerated.

Again, I would like to return to the fact that this is a complex problem. If you take an individual who has a problem with alcoholism, we need to know a great deal about his environment, his background and personality and that of his family. We should study his individual strengths and weaknesses as they pertain to his total situation. He may have difficulties with his relationships with fellow human beings, or he may have spiritual, or medical or psychological or economic difficulties or a combination of some or all of these. We must look at these people individually and not treat them all alike.

We know that inpatient treatment services alone are not the answer to the problems of a person suffering with alcoholism. There is a great need for active follow-up care in the community as a continued service after inpatient treatment. We need education, counseling and better coordination of the treatment and rehabilitative aspects of alcoholism. A better and closer working relationship between local and regional programs can help bring about this better continuity of care and assist in looking at the total problem.

When we consider the fact that there are apparently many factors in the etiology of alcoholism, it is not difficult to predict that if only one aspect of the causation is dealt with, failure in treatment is practically inevitable. Let me mention briefly some of the programs and means of treatment that are available to us.

First, we need to continue, improve and evaluate the services provided through court programs and intensify our efforts to establish, upgrade and evaluate industrial programs.

The means of treatment include individual and group psychotherapy, aversion therapies and the use of medication or drugs.

Counseling of varied types, including specialized family therapy techniques, have been successful. Group psychotherapy seems to be one of the most effective methods.

The use of disulfiram (Antabuse) discourages the impulsive drinker because it makes him violently ill with nausea and vomiting if taken with alcohol. In my experience, as well as others, the most successful results with Antabuse are with patients who continue a positive relationship with a therapist or counselor while taking it. More aversion techniques need to be tried, and there have been other aversion or deterrant drugs such as Flagyl that are still in the experimental stages of study.

In prescribing medication or other drugs for patients who are already dependent on alcohol, the physician must be careful in the type of drug he chooses in order to minimize the chances of the patient becoming dependent on a second drug. He should

also caution the patient about side effects and the dangers of taking drugs and drinking.

Finally, I should mention that Alcoholics Anonymous has been very successful with many persons affected by alcoholism. The companion organizations, Al-Anon and Alateen, have helped by providing help for the families of alcoholics. More of these groups should be developed and used more often.

In closing, remember that alcoholism is complex but it is treatable and almost everyone has something to contribute toward relieving this huge problem. We hope some day, by all working together, to be able to prevent it through knowledge, research, education and treatment.

PILOT STUDY

(CONTINUED FROM PAGE 11)

found that a problem drinker was involved—directly or indirectly—in a little over four out of ten patients admitted to these two mental health centers. Also, about four out of ten of the problem drinkers lived in the same household.

In approximately one-fourth of the cases the father, alone, was the problem drinker. Also, in nearly one out of eight cases, the problem drinker was the patient himself.

This was a pilot study, and it indicates to some degree the magnitude of the problem drinker in relation to patients seen in the two mental health centers. But, a word of caution, one must keep in mind the differences between the various distributions of these two mental health centers. These percentages may not hold up for other mental health centers or for the whole state.

This study does show the need for a more controlled and broader study dealing with this problem.

COMPREHENSIVE SERVICES

(CONTINUED FROM PAGE 8)

programs, one alcoholism program and/or one alcoholism information center in each mental health area, providing public information, education, counseling, referral, treatment and rehabilitative services.

2) The Walter B. Jones Alcoholic Rehabilitation Center in Greenville, a 76-bed inpatient intensive treatment unit for sober, motivated alcoholics—individuals who volunteer directly, or committed patients transferring from the Cherry unit after screening and motivation.

3) The Cherry Hospital Alcoholic Treatment Unit for the treatment of chronic alcoholics, patients who have been legally committed.

4) A domiciliary unit for selected patients (clients) who are certified by vocational rehabilitation and placed in this unit for treatment and rehabilitation under the direction of the Division of Vocational Rehabilitation.

We see these four components as the basic entities of a viable network of services, each providing parts of the comprehensive program for the region, each working together, collectively sharing ideas, jointly developing plans and working together to implement a system of services, all working cooperatively with other agencies, groups and professions in the promotion and implementation of support programs by other agencies and groups, and joint programs with other agencies.

I have described what I believe are the essentials of a comprehensive network of alcoholism services for prevention, care, treatment and rehabilitation. Staff training and training of others in the human services field together with program evaluation are essential program components.

An Account of a Nurse's Role and Functions in an Alcoholic Treatment Program

BY MARCIA MOORE, R.N.

Marcia Moore received her diploma from St. Elizabeth School of Nursing, Lafayette, Indiana, and her Bachelor of Science at Indiana University. She is currently a nurse supervisor, Veteran's Administration Hospital, Marion, Indiana.

"If the nurse does not believe that the alcoholic patient is a sick person with an illness, she may as well forget about helping him. . ."

During the past ten years, mental health authorities have recognized alcoholism as a treatable disease. Although many disciplines have been working with alcoholic patients for several years, the nurse has been a "late comer" to the field of alcoholism. I have received great satisfaction working on a full-time basis in the treatment of the alcoholic patient and my experience shows that nurses have much to offer in this field.

The role of head nurse on an Alcoholic Treatment Program at a Veterans Administration Hospital is challenging and rewarding, but it can also be a very frustrating experience Most nurses have encountered alcoholism countless times throughout their nursing careers: Often one views the alcoholic as a person with no will power, and, for the most part, as being a hopeless case. In this particular Veterans Hospital it was traditional for patients with alcoholic problems to be housed with psychiatric patients and the treatment was essentially the same for both. The alcoholic patient was generally "in trouble" because of his drinking both in the hospital and in the community.

For a more complete understanding of my role in the Alcoholic Program, some background concerning this program is presented. The Alcoholic Treatment Program was started in November 1966. The nucleus of the program was planned by the Coordination Board. This Board consists of representatives from each service within the hospital who are participating in a particular program.

A 73-bed ward was selected to house the patients. The building consists of a large dayroom equipped with television, pool table, large padded chairs, wooden card tables and book cases. There is a large, screened-in porch area off the dayroom. The sleeping quarters consist of three dor-

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mitories with individual wall lockers for each patient in which they keep their clothes and personal articles. There is a quiet room for the patients to use for writing letters, reading, and holding meetings. The basement is a large area divided into a coffee room for the patients, a hospital service clinic maintained by the patients, and a central clothing and storage area. A "Service Clinic" maintained in the basement of the ward is manned by three or four patients. They help with work important to ward operations, e.g., stapling carbons to various VA forms, assembling workbooks and folders for nursing trainees, assembling folders for new admissions, and other "busy" work, thus relieving clerical personnel for other duties.

Voluntary Program

The seven-week voluntary program is headed by a staff representing the various professional services in the hospital. The staff meets with the patient two or three days after he is admitted to the ward. The patient's problems are discussed and the patient participates in the planning of his particular treatment program which will be carried out during the next seven weeks. While in the treatment program, sessions are held with the patient at two-week intervals, to discuss his progress, any problems he may be having, and to help in planning what he will do when he leaves the hospital. Initially, the patient is given a meaningful work assignment in order to help him regain good working habits, and obtain self-satisfaction. Many patients are assigned to a compensated therapy program so that they may earn money while they are in the hospital. The staff attempts to give the patient as much responsibility as possible to help him gain self-respect, confidence, and hope for the future. In addition to their "off the ward" work assignments, all patients have work assignments on the ward, including such duties as keeping the ward neat and clean. They are also responsible for keeping their own clothes in order and are encouraged to budget their money.

Much has been said and written concerning communications between the nurse and the other staff members. Needless to say, every nurse is well aware of her relationship to the doctor, but often the nurse is not too clear about her relationship with other members of the team. As Caplan writes, "The nurse moves freely between two worlds of patient and specialist." It has been my experience that it is an absolute necessity to insure communications between the nurse and staff member in order to work effectively for the best interest of the alcoholic patient. Our method of insuring this communication is through daily staff meetings attended by the ward physician, nurses, nursing assistants, psychologists, chaplains, social service worker, physical medicine and rehabilitation therapists, and others who have pertinent information to share which would be helpful in understanding the patient and contributing to his treatment program.

Several weeks before the program was initiated, inservice classes were given consisting of movies, lectures, and group discussions on alcoholism for all personnel within the hospital. Emphasis was placed on the need for attitude changes and the new trends in the treatment of alcoholism. The nursing personnel who would be working closely with the patient around the clock were selected on the basis of their therapeutic attitude toward alcoholism and their willingness to work within a structured, intensified program dealing with patients whose primary problem was alcoholism.

It was necessary for my "feeling" to undergo radical changes concerning the alcoholic patient. This patient exhibits no defined pain, diseased area, or set pattern of behavior that can be cured with a wonder pill, medical or surgical procedure, or any magical power. The patient cannot be given another anesthetic to alleviate the one which he has already utilized to dull the pain of his suffering. The basic requirements for treatment of the alcoholic are patience, understanding, and a true acceptance from personnel.

An opportunity for the nurse in helping the alcoholic patient is through setting the milieu of the ward. On our ward there are no locked doors and the patients are free to come and go. The ward milieu is relaxed and patients are encouraged to talk with personnel at any time and particularly those times when the patient is experiencing anxious moments, when something is bothering him, and when he is experiencing a "craving" for alcohol. It is important for the nurse to know of the patient's reactions and attitudes toward his treatment and hospitalization, toward the environment, and to other patients. It is important for the patient to know that someone is interested in him and wants to hear about his problems and feelings.

In order to encourage socialization and interaction among the patients, a coffee room is maintained on the ward. The patients, their friends, and relatives provide the funds to support this important phase of the program. The coffee urns are supplied to the ward by the Volunteer Service within the hospital.

To care for the alcoholic on a daily basis may be quite disturbing and trying for both professional and non-professional personnel unless they understand the dynamics of an addictive drinker. Contrary to popular belief, the alcoholic patient is not easy to work with. Achieving sobriety is only the first step. The alcoholic is sick socially, emotionally, spiritually, and physically. Nursing personnel have to be fully aware of the fact that they are dealing with a patient who has many emotional problems, who has a low frustration tolerance, who is impulsive and inconsistent in behavior, and who has feelings of guilt, inadequacy and worthlessness. Many times the alcoholic lacks insight and blames everyone else for his excessive drinking. It is necessary for the nurse to understand that the patient's irresponsibility and rationalization, which stems from his unconscious self-destructive needs, are as symptomatic of the illness as is the excessive drinking of alcohol.

Basis of Selection

Selection for the seven-week treatment program is based on the patient's desire to do something about his drinking problem and his willingness to participate in the program. Many of the patients, upon entering the ward, seem surprised to learn that a nurse will be with them the entire day particularly since they are not receiving medications or treatment. This is due to the preconception some patients have of nurses. Occasionally, it is thought that nurses are authoritarian and cold; and, it is possible that those nurses whose manner is just the opposite, may produce anxiety in patients who think this. If such a patient comes to a nurse who is warm and extroverted, a nurse who makes decisions *with* the patient instead of *for* the patient, the patient's preconceptions will be in conflict with reality. If the nurse is able to recognize this anxiety and tries to clarify what is happening, there is good possibility for growth. Many of these patients have been on alcoholic programs in other hospitals where the

nurse was on the ward for only short periods of time during the day. Therefore, the nurse should communicate her willingness to aid the patients and help them more fully understand about their illness through lectures, movies and group discussions. She should emphasize to the patients her availability to listen to their problems and feelings, to help them maintain an honesty with themselves and to help them gain hope for the future. It is difficult to realize that nurses cannot fulfill their usual role of "nursing" the alcoholic back to health. Nurses need to talk with patients, learn how to listen purposefully and understand what they are trying to convey to her.

One of the difficulties the nurse has to overcome is when the patient looks upon her not as a nurse, but, because of his own past emotional experience, places her in a different role. One patient identified me with his wife, whom he described as a nagging authoritarian person who belittled him continually. At first, I was quite uncomfortable with this patient and it was very difficult to hold my emotions intact without becoming angry. I made it a point to see and talk with this man more often, allowing him to talk out his feelings about his wife and himself without letting myself become emotionally involved.

Frequently the alcoholic patient will "explode" to the nurse for no apparent reason, or become upset when he cannot have something he wants. Patience and understanding are the keys in dealing with this behavior. The nurse must understand that this immature behavior almost always manifests itself in alcoholic patients and she daily will encounter this behavior while working with these patients. The nurse must learn not to take this behavior personally or become angry with the patients, but cope with this behavior in a kind but firm manner without rejecting the patients. Impulsive and inconsistent behavior is dealt with through many different channels. We have found that the success of the program depends upon recognizing each patient as an "individual" with his own contribution to the program, his identification with the other patients and his reactions and their effect upon others.

Adverse behavior is also dealt with through interpersonal relationships with other patients, ward personnel and the staff. The opportunity to learn new means of self-expression is given the alcoholics through small group discussions. These discussions are held weekly with a professional member of the staff "sitting in" with each group. The patients discuss their mutual drinking problems, how alcohol has disturbed their lives, and attempt to find, through such group interaction, some insight and realistic solutions to their problems.

The Patient's Feelings

Because of public opinion of the alcoholic, he may have been degraded, yelled at, misunderstood, threatened and jailed. Generally, the patient expects to find the same type of attitude upon entering a ward which houses only alcoholics. The patient worries about what will happen to him if he "slips" while on the program. Most of the patients will express their surprise that the personnel seem to understand their problems and don't look upon their drinking as a sin or weakness, but as an illness that can be helped. Since the general attitude toward the alcoholic patient has been one of scorn, most patients that come to our program are sadly lacking in self-respect and have feelings of inadequacy and worthlessness. The patient may not know why he behaves in a bizarre manner when he is intoxicated, but he does realize that others have been upset with him and

have put him out of their lives. The patient hopes that the staff, despite his past behavior, will think him worthy of their consideration and help. One of our primary goals is to help the patient in developing a healthy self-image, to help him feel worthy again. Once the patient feels he deserves to be helped, he will try and help himself.

Through education, we attempt to instill hope in the alcoholic patient. Lectures concerning the various aspects of alcoholism are given weekly by professional staff members. The dietitian teaches the fundamentals of proper nutrition and its importance. The social service worker speaks of the patient's responsibility to his family and to his community. The psychologist speaks on depression and anxiety. The nurse presents the medical aspects of alcoholic problems and discusses the 43 steps in the diagnosis of alcoholism as developed by E. N. Jellinek. Movies on alcoholism are shown weekly as a part of the educational program. Many of the patients have made comments indicating that some of the movies seem to illustrate their own lives. Discussion, led by the nurse, follows each movie showing.

Another therapeutic goal of the treatment program is family participation within the actual program. The staff feels that knowing the relatives and the part they play in the patient's life, and helping the relatives to understand more about the patients alcoholic problem is of primary importance. The patients are quite enthusiastic and some comments from the patients to their relatives have been; "I am glad you came today, I wanted you to hear this particular lecture;" "Now you are going to find out all about my problem;" and "I think they came to our house to make this movie, that's our life up there on the screen."

I can remember only one patient who requested that his relatives not attend the program with him. Two weeks later this particular man said to me, "If my relatives come today, go ahead and let them come in; what they don't know is hurting them more than it does me." This particular patient, when first hospitalized, was rather hostile toward his family for committing him to the hospital. On the other hand, one relative of a patient refused very flatly to attend the program when he was asked. The patient had previously stated that this particular relative got into just as much trouble as he did with his drinking, but the relative didn't recognize his own problem.

During the past six months, more relatives have been coming to the ward early in order to attend both the lectures and films. The patients set up extra chairs for the relatives before the program starts and the relatives sit with the patients they are visiting. Slowly, the relatives are becoming more comfortable in participating in the group discussions following the films. I have found that as the relatives become more relaxed and get to know some of the other patients, they comment on the films and add their personal experiences to the discussions.

After the program, coffee is served by the patients and relatives are allowed to walk around and visit the first floor and basement of the building. This gives the nurse an oportunity to talk to them and more fully understand their relationships with the patients. It also gives the nurse the opportunity for health teaching with the family, helping them to gain understanding of the alcoholic and of his disrupted personal life resulting from alcoholism.

Most health authorities recognize that most alcoholics tend to be rather dependent, the degree of dependency varying with each individual patient.

This dependency may increase when placed in a hospital situation where many things are done for the patient and he is rarely given a chance to make a decision on his own. Due to his past drinking patterns and the subsequent possible loss of his job, his family depends less upon the patient and he, in time, comes to depend more on his family. Other basic goals are helping the alcoholic patient become independent in some phases of life, increasing his confidence in accepting responsibility, helping him to accept his illness, and solving his problems through realistic decision making. The relationship between dependency and independency, i.e., interdependency, plays an important part in getting the alcoholic to accept help and yet helping him to stand on his own feet. It is necessary for the nurse and the patient to feel interdependent. The nurse is dependent upon the patient to give her correct information concerning his feelings, drinking patterns and other events and the patient is dependent upon the nurse for her understanding, acceptance of him, and the giving of information and knowledge on alcoholism.

Positive Relationship

It is an absolute necessity for the nurse to establish a positive and therapeutic relationship with the alcoholic patient in order to gain his trust and confidence so that the nurse with her special knowledge and skills can provide beneficial care. Gaining the patients trust cannot be overemphasized in the alcoholic treatment program. The nurse must gain the confidence of the patient in order for the patient to feel secure, relaxed and more willing to actively participate in the program. When patients are distrustful, they just cannot "get with" the program. These patients are difficult to help as they are defensive, guarded, demanding, and are concerned about everything but the alcoholic problem. Everyone needs the feeling of trust, but the alcoholic patient continually looks for this trust in personnel. The nurse should maintain a personal concern for the distrustful patient, giving support and reassurance.

Many alcoholics feel they are alone. Some of them are divorced or separated or their relationship with their families is shattered due to their drinking. Their friends have left them. They feel their world has fallen apart and they have turned to the hospital to help them pick up the pieces. Nurses give support to these patients in many different ways: by accepting them as a people who can be helped, by kindness, patience, thoughtfulness, and respect for them as individuals.

Nurses are seeing patients in individual and in group therapy. Available studies seem to demonstrate that long lasting results can be achieved primarily through this technique known as psychotherapy. Generally, a trained professional person works with the patient to help him recognize, through self-examination and guidance, his feelings, attitudes and behavior in order to bring about more effective living. We accept the theory that the psychotherapeutic approach in alcoholism usually involves an attempt to help the patient accept himself as an alcoholic and as a person who is sick and in need of help. An effort is made to help the patient acquire an understanding of his tensions and anxieties, to find workable methods in dealing with these feelings that will enable the patient to live with those problems that cannot be solved. Most therapists have found that pleading with the patient, telling the patient how to live his life, or urging him to use more will power, are usually useless and may be destructive.

The hospital chapter of Alcoholic Anonymous meets twice weekly on

the ward, and cake and cookies are provided by the hospital dietetic department following the meetings. The public address system and any other needed equipment is secured through our recreation department. Our patients are guests of the local community chapter once a week. The staff also emphasizes to relatives and friends of the patients their utilization of Al-Anon Group which is a fellowship of husbands, wives, relatives, and friends of problem drinkers. These people come together in the effort to solve their common problems in trying to understand the alcoholic and in trying to deal with their own insecurities and unorganized personal lives resulting from alcoholism. The hospital Al-Anon Group meets once a month and invitations are sent to the relatives when the patient is admitted to the alcoholic program.

Self-Management Encouraged

In order to promote and give encouragement toward self-management, two active committees are maintained on the ward with representatives from the staff as counselors. The Alcoholics Anonymous Steering Committee is composed of patients who make arrangements for refreshments and plan for the speakers on Alcoholics Anonymous nights. They also maintain the Alcoholics Anonymous materials in the library. The patient council is a liaison between the patients and the staff. Many ward problems are taken care of in the council in order to relieve the staff of this added responsibility and to foster experiences in self-management. The council also talks with patients who are not adhering to the policies of the building and patients who are on the verge of a "slip".

During the past 18 months, there have been many changes within the program which have been brought about through the efforts and requests of the patients themselves. One major change was the length of the program. Originally, the program was set up for a period of four weeks. The patients maintained that it took at least four weeks for their attitudes to change and for them to recognize and get a "good grip" on their problems. The program was then extended three weeks and longer for some patients who needed more extensive vocational counseling in finding suitable employment upon discharge. This also allowed time for patients whose families needed more social service counseling in helping the family to accept and understand the alcoholic and help him make a therapeutic adjustment back into the home.

Approximately a week before the patient is scheduled for discharge, he is given a "test" of several questions covering the book, *Alcoholics Anonymous Comes of Age*. The patient is also given a questionnaire in which he is asked to describe what he had gained from the group, what was most beneficial in his treatment, what he feels now about his drinking problem, and what problems he anticipates immediately after leaving the hospital. After these questionnaires are completed, the nurse, social workers, and other staff members discuss the questionnaire with the patient and attempt to help the patient with any "last minute" problems.

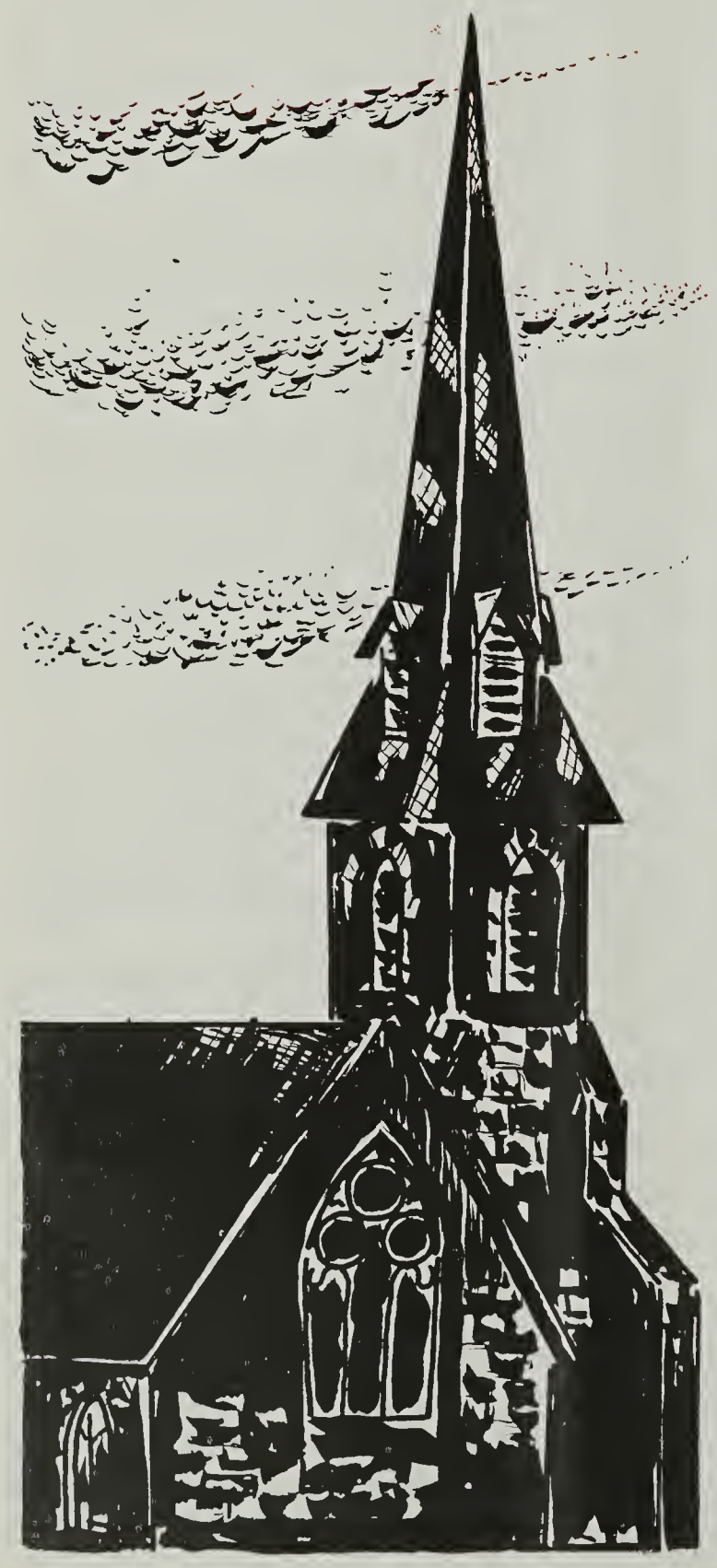
It has been found that not everyone can work therapeutically with the alcoholic patient. In order for the nurse to establish a good working relationship with the alcoholic patient, she must possess certain characteristics that will prevent her from exploiting the patient in order to serve her own needs. If the nurse does not believe that the alcoholic patient is a sick person with an illness, she may as well forget about helping him, as the alcoholic seems to know

(CONTINUED ON PAGE 31)

A sermon on alcohol problems

"To do the right deed for the wrong reason"

The Greatest Treason



BY THE REVEREND WILLIAM DONALD MOORE

In *Murder in the Cathedral*, T. S. Eliot has Archbishop Beckett utter a line that has relevance for "Alcohol and Drug Problems Sunday:"

> **The last temptation is the greatest treason: To do the right deed for the wrong reason.**

To do the right deed, or the right thing, for the wrong reason points to a distortion in perception. Using the eye as a symbol Jesus sees distorted perception as the pathway to complete darkness.

> **If your eye is sound, your whole body will be full of light; but if your eye is not sound, your whole body will be full of darkness. If then the light in you is darkness, how great is the darkness! (Matthew 6:22-23)**

Our basic premise is what we interpret to be the position of the Bible and the position of the great majority of the historic Christian Church both now and through the ages. This position is that the right thing can be either to drink or to abstain from alcoholic beverages. The Hebrew in the Old Testment looked upon the fruit of his vineyard—food and wine—as a good gift of Holy God. Like any other gift of God, wine was to be enjoyed and used responsibly; thus the Psalmist could write, "Wine maketh glad the heart of man." Freedom of choice was the supreme gift

Rev. Moore is minister of Halifax United Methodist Church, Halifax, N. C. This article was his sermon on "Alcohol and Drug Problems Sunday." He belongs to his county mental health association and is an experienced alcoholism counselor and public school teacher. He received his training at Rutgers University and the Veterans Administration Hospital Salisbury, N. C.

of God; therefore, the Hebrew could choose to drink or abstain. Although some Hebrew groups were abstainers, there is no evidence that abstinence is more acceptable to God than drinking. Drunkenness, the abuse of wine, however is explicitly condemned.

In the New Testament Jesus never uttered one word against the drinking of wine. Rather, one gets the picture that he entered fully into the religous and social life of the community in which wine was used in religious ritual and as a symbol of fellowship such as the wedding at Cana. Significantly one of the symbols that He chose to mediate Himself in the Last Supper was an alcoholic beverage. As in the Old Testament, only the abuse of wine is condemned.

Because of the attitudes toward alcohol that have been conditioned into most of us as Methodists (Bible-Belt Protestants generally), it is exceedingly difficult for most of us to perceive of the above paragraphs as Biblical.

The attitudes that have been associated with total abstinence over the years have said in effect: alcohol is evil, drinking is sin, total abstinence is the more Christian position and overcoming an alcohol problem is simply a matter of will power. This is oversimplification, of course, but it is uncomfortably close to the real thing. If you have any question about it, visit some A.A. groups in the Bible-Belt and listen to recovered alcoholics tell about the religious and cultural alcohol education that most of them received as children. One consistently hears a Bible-Belt A.A. talk begin:

> **I was reared in a good Christian home. My mother and father were good Christian people. We never had alcohol in our home. (If either parent drank, it was usually father and this was before he was saved). I was in church and church school every Sunday.**

Like a broken record, it plays on and on as the voice of judgment on Bible-Belt Protestantism's alcohol education.

Usually, sermons on alcohol are aimed at those who drink while those who abstain sit comfortably in self-righteous judgment. At least this was especially true on "Commitment Sunday" when I grew up.

Today, however, I am talking to this entire congregation: those who drink (which is the majority), and those who abstain; because studies have led me to believe that both groups are equally guilty in their contribution to alcohol problems.

As has been stated the "right thing" in the Christian faith can be either to drink or to abstain, but because of the alcohol education we have received we do the "right thing for the wrong reason." I am contending that this is one of the reasons that studies (Skolnick, Mulford and others) are consistently showing higher rates of drinking problems among Methodists and like Protestant groups than among religious and ethnic groups who have historically taken a more Biblical position.

We need to remember that the Scriptures do not answer the question, "Should I or should I not drink?" Those of you who abstain may do so for the wrong reason. My Rutgers

University Professor, John Keller, puts it well: "The person who abstains because he believes alcohol is evil has an unhealthy reason. He is condemning a gift of God and he is also standing in judgment over our Lord who drank wine. Often inherent in this reason is a 'holier than thou' attitude toward people who drink. Any reason that results in such a judgmental attitude is a sinful and unhealthy reason for abstinence." Attitudes, such as the above, contribute to problem drinking in just as direct a manner as the person who sells alcohol or the person who drinks.

Healthy Reasons

A healthy reason for abstinence is that it may be practiced as a Christian virture, a matter of self-denial as the expression of personal conviction that it is the best exercise *for me,* or of my Christian freedom and responsibility in relationship to my neighbor. Other sound reasons for abstinence are found in the person who simply doesn't care to drink and in the person who for reasons of health chooses not to drink. The person who holds these convictions comfortably allows other people to make a different decision.

In addition Keller lists two healthy or right reasons for drinking. The first is religious which is best seen by the use of an alcoholic beverage in the Mass of Roman Catholics and in the Holy Communion of certain Protestant Churches. Here an alcoholic beverage (true to the Biblical tradition) is seen as a mediator of the divine. Such use is moderate, but primarily the context of its use is of central importance.

The second healthy use which Keller lists is beverage-social. This is moderate drinking like that done and approved in the Biblical record. A degree of relaxation and well-being from the mild anaesthetic effects may be obtained. In this social use, an alcoholic beverage may be drunk before and after a meal. If it is on the table, it will be included in the gifts for which thanks is given to God. Alcoholic beverages may be drunk as a part of being together socially. The persons who drink for these reasons have no unhealthy dependence on alcohol.

Now, to those of you who do drink (and this includes the majority of this congregation and the majority of Methodists), because of the kind of alcohol education you have received, you may drink for the wrong reasons.

Keller lists them for us: The first is superficial. Drinking becomes the measuring stick for a person's status, worth, and acceptance as a human being. Common phrases describing this kind of drinking are "smart," the "popular thing to do," "evidence of distinction," "sign of being grown up," "to belong to the group," "for business reasons." Drinking, the use of a gift of God, has nothing to do with any of these, and yet in our culture much drinking is done for these reasons. That's what we call superficial.

The next unhealthy reason that Keller lists is rebellion. Some people drink to express unresolved hostility toward authority figures in their lives. Especially is this true among adolescents and young adults. Alcohol drunk even in moderate amounts for such a reason is not truly moderation.

Another "wrong reason" people drink is what Keller calls violent. This reason is reflected in our drinking vocabulary in such terms as "beer blast," "shot," "slug," and "bender." These are violent terms which evidence the mood of much of our drinking and the distorted use of a gift of God. Also because of our cultural conditioning alcohol is often consumed in guilt and for escape. This compounds the problem as the consuming individual is often severed from the healing community.

In her very brilliant and unforget-

able lecture on Shirley Jackson's *The Lottery*, Ruth Smith of the English Department of North Carolina Wesleyan College would call this "disassociated symbolism." In other words the experiental encounters out of which the symbols grew had become disassociated from their roots. The same thing has happened to United Methodists and other Protestants generally with alcohol.

Clinebell, James and others observe that because of its power to give experiences of the ecstatic and the transcendent alcohol found widespread use as a symbol of these elements in religion. Wine, it should be noted, was, and is, often used in those religious rites and festivals related to man's existence, such as birth, marriage, and death. It may be that when alcohol loses its associations with the mysteries of life (and the ritual ways of handling them) as it has for many in our culture, it tends to be used in an unrestrained manner. In this sense alcohol abuse is idolatry, disassociated symbolism, pseudo religion or to fit Erich Fromm's definition of neurosis "a private form of religion."

No Hint of Abuse

Assuming that behavior is learned, I shall never forget my friend Maxwell N. Weisman, M.D. relating his learning about alcohol. He was about five. Wine was placed on the table and blessed as a gift of God along with other food. In this learning experience there could be no hint of the abuse of alcohol which differes radically from usual Protestant alcohol education.

These times call for an analysis of our attitudes as alcohol problems have grown within our ranks. Because of our past alcohol education, perhaps we have commited the greatest treason: "To do the right thing for the wrong reason."

A NURSE'S ROLE

(CONTINUED FROM PAGE 27)

intuitively how people feel about him.

What has been most difficult for me is to understand and evaluate my thinking in terms of not curing the alcoholic, but in terms of improvement. At first, it was quite discouraging to see a patient returning to the program three or four months after his discharge, but the nurse must realize that any length of sobriety for a patient is to be considered a positive accomplishment and sign of progress for the patient.

All nurses, no matter what their field of specialization, will encounter patients with alcoholic problems. Their effectiveness in dealing with these problems will depend largely upon understanding the dynamics of the addictive drinker, and the techniques that have been effective in the treatment and rehabilitation of the alcoholic and the prevention of continued alcoholism.

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DIRECTORY OF OUTPATIENT FACILITIES BY COUNTY —for ALCOHOLICS and/or THEIR FAMILIES

Key to Facilities

+ Community Alcoholism Program
(supported jointly by the community and the N. C. Department of Mental Health)

*** Community Alcoholism Program**
(supported largely by funds from local boards of alcoholic beverage control)

‡ Joint Mental Health and Alcoholism Services
(supported by the community and the N. C. Department of Mental Health)

† Mental Health Facility
(supported by the community and the N. C. Department of Mental Health whose services are available to alcoholics and their families)

Competent Help Is Available At The Local Level

ALAMANCE—

+ *Alamance County Council on Alcoholism*, Room 802, N. C. National Bank Bldg., Burlington 27215; Tel: 919-226-4403.

† *Alamance County Mental Health Clinic*, 221 Graham-Hopedale Rd., Burlington 27215; Tel: 919-227-6271.

ALLEGHANY (See Watauga)

ANSON (See also Stanly)

* *Education Division, Board of Alcohol Control*, 127 Wade St., P. O. Box 39, Wadesboro 28170; Tel: 704-694-2711.

AVERY (See Watauga)

BEAUFORT (Hyde, Martin, Tyrrell, Washington)—

† *Tideland Mental Health Center*, 418 West Second St., Washington 27889; Tel: 919-946-4640.

BERTIE (Hertford, Northampton, Gates)—

† *Roanoke-Chowan Mental Health Service*, 316 South Academy St., Ahoskie 27810, Tel: 919-332-4137 (main office); and 108 Dundee St., P. O. Box 143, Windsor 27983, Tel: 919-794-2895 (sattelite).

BLADEN (See Robeson)

BUNCOMBE—

† *Alcohol Information Center*, Parkway Offices, Asheville 28802; Tel: 704-252-8748.

† *Mental Health Center of Buncombe County*, 415 City Hall, Asheville 28801; Tel: 704-254-2311.

BURKE—

Burke County Council on Alcoholism, 211 N. Sterling St., Morganton 28655; Tel: 704-443-1221.

CAMDEN (See Pasquotank)

CARTERET (See Craven)

CABARRUS—

† *Cabarrus Mental Health Complex*, 102 Chruch St., N.E., Concord 28025; Tel: 704-786-1181.

CATAWBA—

Catawba County Council on Alcoholism, 420 Seventh Ave., S.W., Hickory 28601; Tel: 704-328-3564.

CHOWAN (See Pasquotank)

CLEVELAND—

† *Cleveland County Mental Health Clinic*, 101 Brookhill Rd., Shelby 28150; Tel: 704-482-3801.

CRAVEN (Carteret, Jones, Pamlico)—

‡ *The Neuse Clinic*, 2000 Neuse Blvd.:

+ *Alcohol Information Division*, P.O. Box 2535, New Bern 28560; Tel: 919-638-4171.

+ *Alcohol Information Division*, 506 Broad St., P. O. Box 82, Beaufort 28516; Tel: 919-728-4033.

COLUMBUS (See Robeson)

CUMBERLAND—

† *Cumberland County Mental Health Center*, Cape Fear Valley Hospital, Fayetteville 28302; Tel: 919-484-8123.

CURRITUCK (See Pasquotank)

DARE (See Pasquotank)

DUPLIN (See Onslow)

DURHAM—

† *Department of Psychiatry*, Duke University Medical Center, Durham 27706; Tel: 919-684-8111, Ext. 3416.

Durham Council on Alcoholism, 602 Snow Bldg., Durham 27702; Tel: 919-682-5227.

EDGECOMBE (NASH)—

† *Edgecombe-Nash Mental Health Center*, 359 Falls Rd., P. O. Box 2312, Rocky Mount 27801; Tel: 919-442-8021.

FORSYTH—

† *Department of Psychiatry*, Bowman Gray School of Medicine, N. C. Baptist Hospital, Winston-Salem 27103; Tel: 919-725-7261.

† *Forsyth County Department of Mental Health:*

† *Alcoholism Program of Forsyth County*, 802 O'Hanlon Bldg., 105 W. 4th St., Winston-Salem 27101; Tel: 919-725-5359.

† *Forsyth County Mental Health Unit*, 1020 E. 7th St., Winston-Salem 27101; Tel: 919-722-0364.

FRANKLIN—

† *Franklin County Family Counseling and Education Center*, Rt. 1, Box 1X West, River Rd., Louisburg 27549; Tel: 919-496-4111.

GASTON

† *Gaston County Mental Health Center:*

† *Center for Alcohol Related Problems*, 302 S. York St., Gastonia 28052; Tel: 704-864-9771.

GATES (See Bertie)

GUILFORD—

Alcohol Education Center, P. O. Box 348, Jamestown 27282; Tel: 919-454-2794.

Family Service Agency, 1301 N. Elm St., Greensboro 27401; Tel: 919-273-0523.

Family Service Agency of High Point, 113 Gatewood Ave., High Point 27260; Tel: 919-883-1709 or 919-833-2119.

† *Greensboro Council on Alcoholism*, 216 W. Market St., 206 Irvin Arcade, Greensboro 27401; Tel: 919-275-6471.

† *Guilford County Mental Health Center*, 300 E. Northwood St., Greensboro 27401; Tel: 919-273-8281.

† *Guilford County Mental Health Center*, 942 Montlieu Ave., High Point 27262; Tel: 919-888-9929.

HALIFAX—

† *Halifax County Mental Health Center*, 701 Jackson St., P. O. Box 577, Roanoke Rapids 27870; Tel: 919-537-6174.

HARNETT (See Lee)

HENDERSON—

Alcohol Information Center, 2nd Floor, City Hall, P. O. Box 472, Hendersonville 28739; Tel: 704-692-8118.

† *Henderson County Mental Health Clinic*, 820 Fleming St., Hendersonville 28739; Tel: 704-692-2138.

HERTFORD (See Bertie)

HOKE (See Moore)

HYDE (See Beaufort)

IREDELL—

† *Iredell County Mental Health Clinic*, 221 South Center St., Statesville 28677; Tel: 704-872-7901.

JONES (See Craven)

LEE (Harnett)—

† *Lee-Harnett Mental Health Clinic:*

+ *Division on Alcoholism*, 106 W. Main St., P. O. Box 2428, Sanford 27330; Tel: 919-755-4129 or 919-755-4130.

LENOIR—

† *Lenoir County Mental Health Clinic*, 111 South McLewean St., Kinston 28501; Tel: 919-527-1196.

MARTIN (See Beaufort)

MECKLENBURG—

Charlotte Council on Alcoholism, 1125 E. Morehead St., Charlotte 28204; Tel: 704-375-5521.

† *Mecklenburg County Mental Health Center*, 316 E. Morehead St., Charlotte 28202; Tel: 704-334-2834.

The Randolph Clinic, Inc., 1804 East Fourth St., Charlotte 28204; Tel: 704-333-9026.

MONTGOMERY (See Moore)

MOORE—

Moore County Alcoholism Program, P. O. Box 1098, Southern Pines 28387; Tel: 919-692-6631.

† Sandhills Mental Health Center (Hoke, Montgomery, Moore, Richmond):

† *Alcoholism Services*, Medical Center Bldg., Pinehurst 28374; Tel: 919-295-6169.

NASH (See Edgecombe)

NEW HANOVER—

New Hanover County Council on Alcoholism, 211 N. Second St., Wilmington 28401; Tel: 919-763-7732.

† *Southeastern Mental Health Center*, 920 S. 17th St., Wilmington 28401; Tel: 919-763-7342.

NORTHAMPTON (See Bertie)

ONSLOW (Duplin)—

† *Onslow-Duplin Mental Health Clinic*, 225 Wilmington Hwy., P. O. Box 547, Jacksonville 28540; Tel: 919-347-5118.

ORANGE—

† *Alcoholism Clinic of the Psychiatric Outpatient Service*, N. C. Memorial Hospital, Chapel Hill 27514; Tel: 919-942-4131, Ext. 336.

† *Orange-Person Mental Health Center*, 413 W. Rosemary St., Chapel Hill 27514; Tel: 919-929-4723 or (Alcoholism Counselor) 919-942-4345.

PAMLICO (See Craven)

PASQUOTANK (Camden, Chowan, Dare, Perquimans, Currituck)—

‡ *Albemarle Area Mental Health and Alcoholism Service*, P. O. Box 645, Medical Bldg., Elizabeth City 27909; Tel: 919-335-1663.

PERQUIMANS (See Pasquotank)

PERSON (See Orange)

PITT—

† *Coastal Plain Mental Health Center*, 1827 W. Sixth St., Greenville 27834; Tel: 919-752-7151.

RANDOLPH—

+ *Randolph County Mental Health Unit*, Professional Village, 200 Foust St., Asheboro 27203; Tel: 919-625-2204.

RICHMOND (See Moore)

ROBESON (Bladen, Columbus, Scotland)—

† *Southeastern Regional Mental Health Center*, Medical Arts Bldg., Lumberton 28358; Tel: 919-739-7601.

ROCKINGHAM—

† *Rockingham County Mental Health Center*, P. O. Box 55, Wentworth 27375; Tel: 919-349-7021.

ROWAN—

Educational Division, Rowan County ABC Board, P. O. Box 114, Salisbury 28144; Tel: 704-633-1641.

† *Rowan County Mental Health Clinic*, Community Bldg., Main and Council Sts., Salisbury 28144; Tel: 704-633-3616.

SCOTLAND (See Robeson)

STANLY (See also Anson)

† *Yadkin-Pee Dee Mental Health Proram*, 935 N. Fifth St., Albemarle 28001; Tel: 704-982-5916 or 704-982-7717., and 123 E. Wade St., Wadesboro 28170; Tel: 704-694-4070.

TYRRELL (See Beaufort)

VANCE—

† *Vance County Mental Health Clinic*, County Home Rd., Henderson 27536; Tel: 919-492-1176 or 919-438-4813.

Vance County Program on Alcoholism, 158 Bypass W., P. O. Box 1174, Henderson 27536; Tel: 919-438-3274 or 919-483-4702.

WAKE—

† *Mental Health Center of Wake County*, Wake Memorial Hospital, Raleigh 27610; Tel: 919-834-6484.

Wake County Health Department, 3010 New Bern Ave., Raleigh 27610; Tel: 919-833-1655.

WASHINGTON (See Beaufort)

WATAUGA (Alleghany, Avery, Wilkes)—

† New River Mental Health Center:

+ *Division on Alcoholism*, 210 W. King St., Boone 28607; Tel: 704-264-8759.

+ *Division on Alcoholism*, 101-A W. Main St., Wilkesboro 28697; Tel: 919-838-3551.

WAYNE—

+ *Wayne County Mental Health Clinic* 715 East Ashe St., Goldsboro 27530; Tel: 919-735-4331, Ext. 256.

WILSON—

Wilson County Council on Alcoholism, Room 308, 116 S Goldsboro St., Wilson 27893; Tel: 919-237-0585.

† *Wilson County Mental Health Clinic*, Encas Rural Station, Wilson 27893; Tel: 919-237-2239.

WILKES (See Watauga)

EDUCATION AND INFORMATION SERVICES

INVENTORY—quarterly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from the Film Library, N. C. State Board of Health, Raleigh, N. C. Please request films as far in advance as possible and state second and third choices.

The New Cornerstones—Family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

Library Books—Books on alcoholism are available from the North Carolina State Library through local libraries to residents of North Carolina. To obtain any of the books listed in the March-April, 1964 issue of **Inventory**, go to your community library and make the request.

Staff Speakers—members of the Raleigh and A.R.C. staffs are available for speeches before civic and professional groups.

Teacher's Guide—kit containing reference material and pamphlets on alcoholism and mental health. Available to teachers from the Education Division, N. C. Department of Mental Health, Raleigh.

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